MEDICAL LIABILITY: A PHYSICIAN'S PERSPECTIVE — PAGE 8

Tame Your Health Care Costs! PAGE 13

Health Care News

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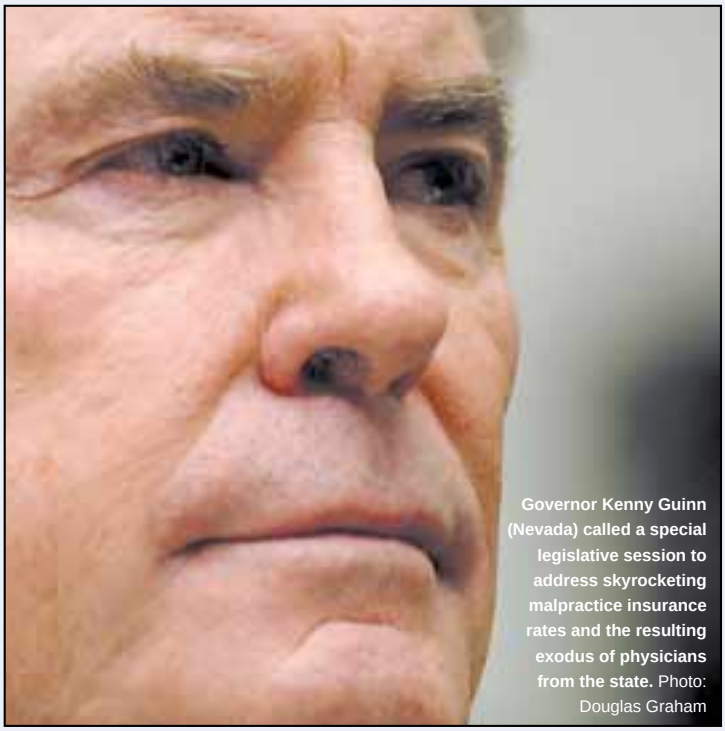
States Taking the Lead on Medical Malpractice Reform



Governor Kenny Guinn (Nevada) called a special legislative session to address skyrocketing malpractice insurance rates and the resulting exodus of physicians from the state. Photo: Douglas Graham

BY JAMES M. TAYLOR

The United States Senate killed by inaction a malpractice reform bill approved by the House of Representatives. But the federal government's inability to act failed to deter several states from taking the matter into their own hands, acting to rein in excessive jury verdicts.

Senate Fails to Act

On September 26, the House passed by a 217-203 vote H.R. 4600, the "Help Efficient, Accessible, Low Cost, Timely Healthcare" (HEALTH) Act. The bill, introduced by Reps. Jim Greenwood (R-Pennsylvania) and Christopher Cox (R-California), would cap non-economic damages at $250,000. It also:

- limits contingency fees paid to attorneys;
- imposes time limits on filing new lawsuits;
- limits punitive damages to the greater of either $250,000 or twice a plaintiff's economic damages;
- deducts insurance payments from damages awards;
- limits a defendant's liability to his or her share of culpability; and
- respects preexisting state damages

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Health Policy Reform High on Agenda for 108th Congress

Inaction by the 107th means malpractice and Medicare reform, prescription drug coverage and aid to the uninsured, remain on the table

BY JOE MOSER

Congress has a wide range of health policy reforms to consider when it opens its 108th session this month. Among the issues it is expected to address are a Medicare prescription drug benefit, the uninsured, making health insurance affordable, medical malpractice reforms, Medical Savings Accounts, Association Health Plans, and Medicare and Medicaid reform.

One of the reasons so many issues remain to be addressed is the inaction of the 107th Congress. While many health-related bills passed one of the two houses, only the Trade Act of 2002 was signed into law. That measure gave tax credits for health insurance to trade-related displaced workers and other retirees, and financial aid to state high-risk pools.

The chances of passing free-market health policy reforms are better now than they were last year. Republicans' success in the November 2002 elections means the same party now controls the White House, House, and Senate. That should help synchronize the agenda in the House and Senate, although bipartisan support still will be needed to pass any substantial health policy reform measure.

Medicare Prescription Drug Benefit

Passing a prescription drug benefit for senior citizens is a top priority for leaders of both parties. Republicans prefer reform proposals that use private competing drug insurance plans to deliver the drug benefit, with extra subsidies for low-income seniors. Democrats have called for a

CONGRESS continued on page14

U.S. Betrayed by WTO Patent Policy

BY ROBERT GOLDBERG

President George W. Bush's diligence in enlisting allies to fight terrorism and disarm Saddam Hussein is paying off, but the United States all but capitulated in its efforts to protect vital pharmaceutical and biotech patents during recent trade talks.

While Bush's recent diplomatic successes have been getting front-page attention, U.S. Trade Representative Robert Zoellick quietly has been stripping away patent protection for America's pharmaceutical and biotechnology industries—apparently to appease the anti-capitalist delegates who dominate the World Trade Organization negotiations on global health.

That's especially ironic because the Bush administration has stood up to the opponents of democratic capitalism in other crucial forums when the pressure was far greater. But Zoellick privately has told confidantes he is conceding on the patent protection issues because the pharmaceutical and biotech industries—unlike steel or agriculture—lack congressional support.

Although stopping the spread of global disease is a compassionate part of the Bush global doctrine, Zoellick's latest concessions are a cave-in to activists more concerned about killing off free-market medicine than about saving lives.

Copy Any Patent

Their latest move—one Zoellick unwisely has acceded to—is to allow any country to import

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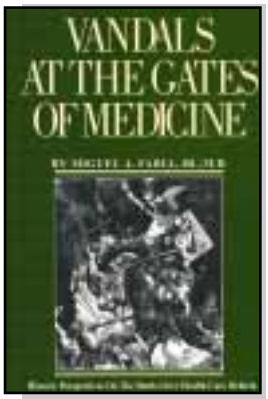


Vandals At The Gates of Medicine

Historic Perspectives on The Battle Over Health Care Reform

Miguel A. Faria, Jr., M.D.

Miguel A. Faria, Jr., M.D. provides compelling arguments that answers to the dilemma of health care reform reside on the pages of history. This fascinating book draws parallels between the past and the present, from a time when the fine line separating myth and history was blurred and indistinguishable to the clearly troubled present.

(403 pp., 1995, Illustrations, Bibliography, Index, ISBN: 0-9641077-0-8, $41.95)

Code Blue

Health Care In Crisis

Edward R. Annis, M.D.

What the press doesn't tell the public—but Dr. Annis does—is that health care problems have a "Made in Washington" label. Code Blue deals with "minimal changes in our tax laws, Medisave accounts would empower the patient by breaking the tie between job and health insurance and even would allow the gradual phasing out of Medicare."

Sold Out!

(278 pp., 1993, Index, ISBN: 0-89526-515-X, $21.95)

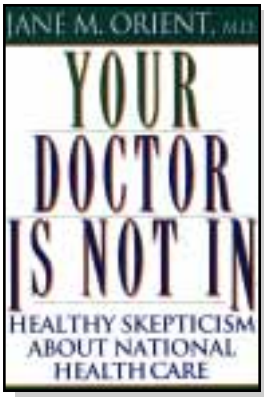
Medical Warrior

Fighting Corporate Socialized Medicine

Miguel A. Faria, Jr., M.D.

In this book of essays, Dr. Faria, argues that managed care and HMOs are not "free market" alternatives, but rather an unholy partnership of government and corporate interests seeking monopolistic government protection to eliminate competition while changing the ethics of medicine from a Hippocratic ethic to a false corporate morality. *Medical Warrior* offers workable solutions to restore medicine to its rightful place.

(207 pp., 1997, Selected Bibliography, Index, ISBN: 0-9641077-2-4, $23.95)

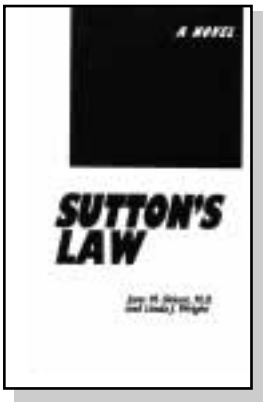


Your Doctor Is Not In

Jane M. Orient, M.D.

In this provocative book, a brilliant, committed physician, a leader in medicine argues for solutions to the crisis in medicine that are bold, thoughtful, and fundamentally opposed to those being widely touted today—including "managed care" systems. From her perspective, there is already too much government involvement in medicine, too much regulation, too much insurance—which is actually prepayment in disguise. These are the root causes of the accelerating rise in fees and costs, the neglect of patients, and stagnation in the science of medicine itself. This book is certain to add fresh energy to the debate over the quality and availability of medical care in America.

(276 pp., 1994, Index, ISBN: 0-517-59011-5, $23.00)



Sutton's Law

Jane M. Orient, M.D. and Linda J. Wright

Sutton's Law is a "frightening realistic novel about where managed care might very well lead us...A mix of medicine, mystery, murder, and intrigue with a little high finance, drugs, and romance—*Sutton's Law* ultimately is about greed and simple justice."

(299 pp., 1997, ISBN: 0-9641077-1-6, $21.95)

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The "Big Vision" for Medicare

BY CONRAD F. MEIER

Heart surgeon and U.S. Senator Bill Frist (R-Tennessee) is stepping into a political swamp wrought with alligators: overhauling Medicare.

Most Republicans are aware they need to deliver prescription drug benefits to the nation's senior citizens in the next two years. They have repeatedly promised to do so, and now they control both Congress and the White House. Democrats, who assert the Republicans simply paid lip service to the issue to get through the elections, are certain to hold conservative feet to the fire if they fail.

The Big Vision

Frist plans to release an initial blueprint of a proposal for broad, long-term Medicare reform by the end of January. He said the proposal would include increased competition among private health plans for Medicare beneficiaries. The proposal will also suggest development of a new health care infrastructure, which could include information and management systems to assess outcomes and allow physicians and patients to exchange information.

Frist, who this month assumes a seat on the Senate Finance Committee, which has jurisdiction over Medicare issues, has said, "Republicans should do more to reform Medicare than simply add a drug prescription benefit."

As reported in *Health Care News*, the House passed in June 2002 a $350 billion Medicare reform bill that included a prescription drug benefit and give-back provisions for providers, but the Democrat-controlled Senate failed several times to pass similar legislation.

Frist said he hopes to pull together all the interested parties and address Medicare reform and the "big-vision" thinking of where the administration wants to see Medicare 10 years from now.

Plenty of Potholes

On hearing of Frist's "big vision," the *New York Times* reported many Democrats oppose any reduction of the role of the federal government in Medicare. According to Representative Ben Cardin (D-Maryland), a member of the House Ways and Means Committee, "If they're trying to reduce the federal government's risk, reduce the federal government's costs, and get seniors into private insurance through vouchers, that's a nonstarter for most Democrats and we'll fight that."

> **"Senator Bill Frist (R-Tennessee) ... plans to release an initial blueprint of a proposal for broad, long-term Medicare reform by the end of January."**

In addition, the *Times* reported Senator Charles Grassley (R-Iowa), who will chair the Senate Finance Committee in the 108th Congress, and Representative Bill Thomas (R-California), who chairs the House Ways and Means Committee, also will weigh in on proposed Medicare reforms. The Ways and Means Committee has jurisdiction over Medicare issues in the House.

Frist asked the *Times*, "Are we ready for really bold change now?" then answered his own question, "I think we are." The reason, he added, was "driven by the demographics in part, but also by the fact that we have a leader [in President Bush] who's willing to do big things and bold things."

Frist acknowledged he probably wants to go further than his party's leadership wants to go, since historically Republicans have been hurt politically when they have tried to overhaul Medicare, a program covering 40 million elderly and disabled Americans.

In the mid-1990s, House Speaker Newt Gingrich's efforts to streamline Medicare and extract $270 billion in savings sparked a political firestorm. Bill Clinton, as President, helped form a bipartisan commission to examine the future of Medicare, headed by Senator John B. Breaux (D-Louisiana), but the commission's recommendations went unheeded during the Clinton years.

"I'm an eternal optimist," said Breaux, who like Frist advocates offering the elderly a private-sector alternative to the single-payer Medicare arrangement.

Scott McClellan, former White House spokesman and now chief of the Food and Drug Administration, said Bush has long supported modernizing Medicare by adding prescription drug benefits and by moving toward a more competitive model, allowing the elderly to stay with traditional Medicare or choose among a variety of private insurance plans.

Conrad F. Meier is managing editor of Health Care News.

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The PULSE

BY GREG SCANDLEN

FREE-MARKET HEALTH CARE REFORM IN THE NEWS

Wisconsin AFL-CIO Wants Single Payer

You've surely heard by now that Oregon's single-payer initiative was defeated by an eye-popping margin of 79 percent to 21 percent. [See "Oregon Voters Rebuff Single-Payer Measure," *Health Care News*, December 2002.) One might think that would put single-payer to rest once and for all. But that would put an entire cottage industry of single-payer advocates out of work, so no such luck.

Instead, we continue to get minor variations on the theme. For instance, the Wisconsin AFL-CIO has decided this would be a swell time to launch a new plan "under which all workers in the state and their dependents would be covered under a single health plan paid for by assessments levied on employers," according to Julie Jacob in *AMNews*. The article says, "details of the plan ... have not been hammered out yet," but proponents are confident it would lower costs by 25 percent.

Probably it would be unkind to ask how they can predict savings without knowing the details of the proposal. But the state medical society is joining in on the fun. It is blowing the dust off a 10-year-old proposal described as similar to the AFL-CIO proposal, except it would be paid for by that all-purpose easy answer: a tax on cigarettes.

The president of the Medical Society of Milwaukee County is described as being "intrigued" by the AFL-CIO proposal. She calls it, "out-of-the-box thinking."

Source: http://www.ama-assn.org/sci-pubs/amnews/pick_02/bise1111.htm

Fort Wayne Leaders Look to MSAs

Finding "new ways of thinking" is indeed the topic of community meetings all over the country right now. A meeting in Fort Wayne, Indiana was a good example.

It brought together employers, providers, and insurers to discuss how to "stabilize skyrocketing health care prices," according to Doug LeDuc in the *Fort Wayne News Sentinel*. The chief medical officer for Anthem Blue Cross Blue Shield told the group hospitals "don't face pressure to reduce costs through quality improvements, but actually are rewarded for mistakes with increased revenue when they are compensated for the corrective care they provide," writes LeDuc.

A hospital administrator claimed new technologies increase costs, but another executive said "improvements in technology can also lower health care costs." He also said medical savings accounts would help force more efficiency as employees "shop around for the best value in health care." The publisher of the paper, Mary Jacobus, agreed, saying, "The patient is going to have to realize the cost or expense and have some financial investment into the cost."

Source: The article is by Doug LeDuc. There is a fee for accessing articles more than seven days old. Go to http://wwwfortwayne.com

Denver Leaders like MSAs, Too

Anthem was also prominent at a similar meeting in Denver. This one featured a keynote address by Uwe Reinhardt, who said the U.S. can afford to pay more for health care. He predicts health care will consume 28 percent of GDP by 2030, up from 13 percent today, but "what else would you spend your money on? SUVs?"

The *Denver Post* reports Reinhardt also proposed a new tax of $120 billion a year to pay for health care for the poor, but says "health industry leaders ... took a decidedly different approach." They gave a "heavy endorsement" to "bare-bones health insurance coupled with medical savings accounts." They also liked the idea of tax credits "to allow low-income residents to buy health insurance."

Source: http://www.denverpost.com/Stories/0,1413,36%257E33%257E957891,00.html?search=filter

Fort Worth Business Moving to Consumer-driven Health

Consumerism in health care is certainly reaching the mainstream press. The *Fort Worth Star Telegram*, for instance, ran a big article in its business section describing what local employers are doing to hold down costs.

Writer Maria Perotin reports, "companies are unveiling health care plans that charge higher premiums, shift more prescription costs to employees, and offer incentives to workers who rein in health expenses." Later in the article she says employees will pay 19 percent of their costs and 24 percent for dependents, up from 18 percent and 23 percent. That hardly sounds like a crisis, although a spokeswoman for the local branch of Consumers Union is apoplectic about it. "(Employees) might choose to forego care they need because they can't afford the out-of-pocket costs," she says.

Still, employers seem to be moving decisively towards consumer-driven care. The article features Nokia, with 4,000 workers in the area, which is offering a consumer-driven option. Other companies are using disease management programs, raising Rx co-pays, or simply switching insurers.

Source: http://www.dfw.com/mld/dfw/business/4434722.htm

Enrollment in Individual Market "Exploding"

Meanwhile, the individual market is suddenly looking pretty healthy, according to *Managed Care Week*. The article says WellPoint has found stagnant sales in the large and small group markets, but "improvement in the individual segment as laid-off employees selected coverage from us while looking for a new job," according to CEO Leonard Schaeffer.

Cobalt Blue CEO Tom Hefty is quoted as saying in Wisconsin "the individual market in the last two years has exploded. We are doubling sales every year in the individual market. ..." He adds, "the trend towards defined contribution is going to accelerate that. If you look at a 30 percent employee contribution, a 25-year-old can buy cheaper individual coverage on his own."

And Anthem CEO Mike Smith says his company added 54,000 new individual members during the first half of 2002. Humana's chief actuary, John Bertko, says, "The intersection of the small end of the small group market and the individual market, at least in our perspective, shows that the individual will grow and probably the small end of the small group market is going to shrink."

Source: The article is not available on-line. It ran in the November 4, 2002 edition of Managed Care Week. For more information. go to http://www.aishealth.com/Products/NewsMCW.html

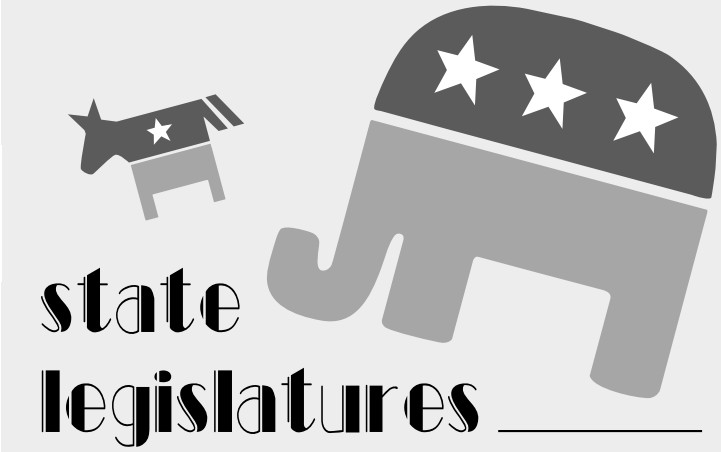
More Private-Sector Expansion

An article by Ron Shinkman in *Healthleaders* reinforces the private-sector trend. This one cites the experience of Humana, Fortis, UNICARE, the Wisconsin Blues, and American Medical Security, all of which report individual enrollment increasing. An AMS spokesman says the company's individual enrollment has "grown in recent years to a par with our small group business."

The article notes the benefits aren't as rich as group plans, and individuals are subject to underwriting, but the market provides a safety net for workers whose employers stop providing coverage.

Source: http://www.healthleaders.com/magazine/feature1.php?contentid=39743&categoryid=153

Greg Scandlen is assistant editor for Health Care News. Log on to http://www.ncpa.org/sub *for Scandlen article archives. Email Scandlen at* GMScan@aol.com.



state legislatures

The most important, least reported outcome of last year's elections are what happened in the state legislatures. According to preliminary results from the National Conference of State Legislatures (NCSL), the Republicans gained a total of 280 legislative seats across the country.

This is a stunning reversal of historical trends. According to NCSL, "the President's party has lost an average of more than 350 seats in every mid-term election cycle since at least 1938." The GOP gained control of five legislative chambers and tied in two others, for a total control of 21 legislatures (up from 17) and split control of eight legislatures, while the Democrats will now control 17 legislatures (down from 18).

Most of the states with Democratic control are in the South (including Alabama, Arkansas, Georgia, Louisiana, Mississippi, Oklahoma, Tennessee, and West Virginia) and are likely as conservative as some of the Northern Republican states.

The NCSL information was passed on to me by Jim Frogue at the American Legislative Exchange Council. I'm sure he will share it with you if you email him at jfrogue@alec.org.

You are invited to participate in an online discussion list dealing with many of the issues we report on here. To check it out, send an e-mail to ***HealthBenefitsReform-subscribe@yahoogroups.com****. Later on, if you want to drop off, just send an e-mail to* ***HealthBenefitsReform-unsubscribe@yahoogroups.com****.*

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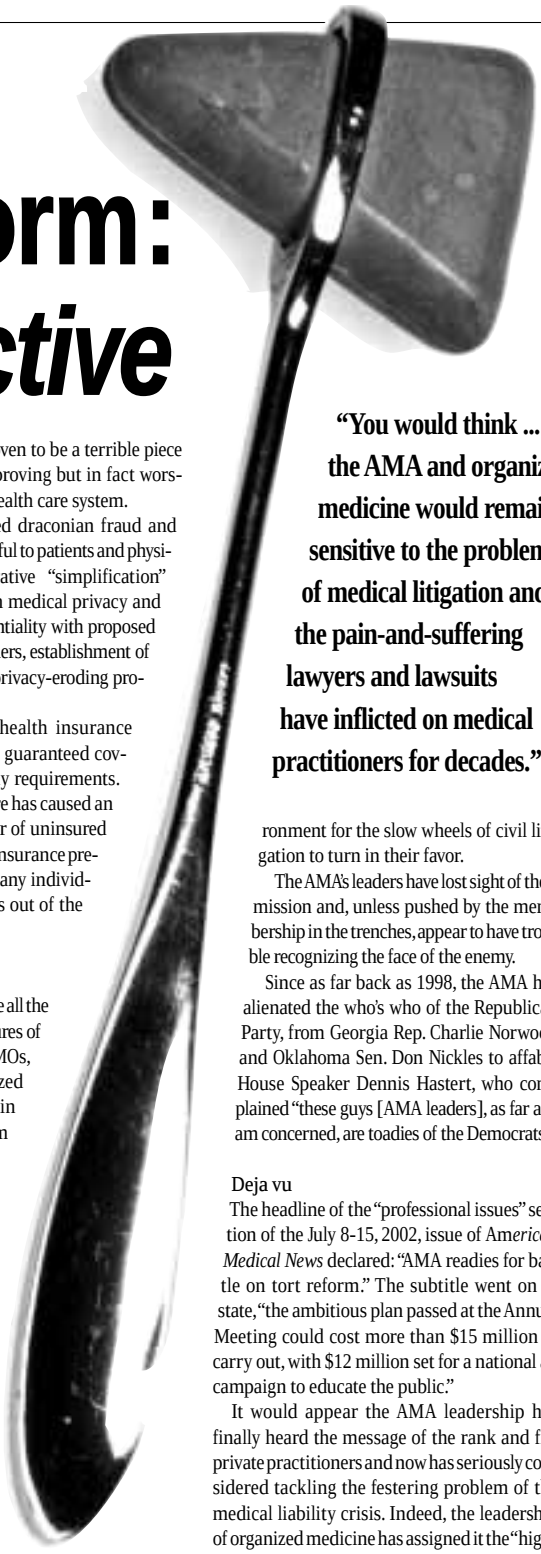
Medical Liability Reform: *A Physician's Perspective*



BY MIGUEL A. FARIA JR., M.D.

With the resurgence of the medical liability crisis, a review of tort reform efforts over the past several years is in order. It's important to understand where we have been and where we are headed in our struggle for meaningful and substantive medical liability reform.

Premiums for physicians are skyrocketing. Medical liability insurers are leaving many states and abandoning their former client physicians, leaving them without coverage. Obstetricians have been particularly hard hit, but the crisis affects every one of us, from physicians to patients.

In Mississippi, 400 doctors are expected to leave the state. At one time, 14 insurance companies provided medical liability coverage in the state; now only one company remains. St. Paul Insurance Company, the second largest medical liability insurer in the country, is not only leaving such states as Mississippi and Georgia, but has decided to get out of the business altogether.

Obstetricians are not the only ones affected. Dr. José Igoa, a 47-year-old psychiatrist, closed his office door and protested in Spring 2002 along with his colleagues in Edinburg, Texas because of soaring insurance premiums, which in 2001 were between three and four times higher than they were five years before. Now, he cannot find a renewal policy at all.

HIPAA Hasn't Helped

True insurance is a mechanism of voluntarily sharing risks, with premiums proportional to the probability of a loss or payout. For physicians, insurance is a mechanism for protecting financial assets. As it has evolved, however, medical malpractice insurance isn't insurance at all. It isn't voluntary, and physicians are required to carry limits that may be far in excess of assets they own.

And the medical malpractice crisis isn't merely a matter of insurance evolving into something else. It's a symptom of a profound cultural transformation: the entitlement mentality, the erosion of contract rights, collective guilt and scapegoats supplanting individual responsibility, the expectation of government-defined and guaranteed "equity" and "social (distributional) justice," and the hubris that all outcomes are under human control.

In the early spring of 1995, the U.S. House of Representatives passed a bipartisan medical liability bill (tort reform) by a significant margin (247 to 171), despite strong opposition by the trial lawyers. The legislation was a sweeping tort reform bill that would have gone a long way towards reforming medical "malpractice" and alleviating the adversarial and litigious climate in which physicians have been practicing medicine for the past three decades.

The measure included a $250,000 cap on non-economic damages, limits on "joint and several" liability, and even a provision for a "loser pays" rule that would have penalized plaintiffs for filing frivolous lawsuits.

Robert E. McAfee M.D., then president of the American Medical Association, called it "a giant leap forward"; not surprisingly, the AMA claimed victory for "its decade-long advocacy on behalf" of physicians. Unfortunately, the AMA's boast turned out to be a premature exercise in muscle-flexing. The Clinton White House threatened to respond to the proposal with a Presidential veto, and medical liability reform never saw the light of day, although some product liability reform did pass.

The Kassebaum-Kennedy proposal, known now as the Health Insurance Portability and Accountability Act (HIPAA), unanimously passed the U.S. Senate in 1996 with the support of the AMA. It has proven to be a terrible piece of legislation, not improving but in fact worsening the American health care system.

HIPAA has enforced draconian fraud and abuse provisions harmful to patients and physicians. Its administrative "simplification" requirements threaten medical privacy and patient record confidentiality with proposed Unique Patient Identifiers, establishment of databases, and other privacy-eroding provisions.

HIPAA increased health insurance premiums because of guaranteed coverage and renewability requirements. As a result, the measure has caused an *increase* in the number of uninsured Americans, as higher insurance premiums have priced many individuals and their families out of the insurance market.

HMO Lawsuits

You would think despite all the shortcomings and failures of managed care and HMOs, the AMA and organized medicine would remain sensitive to the problem of medical litigation and the pain-and-suffering lawyers and lawsuits have inflicted on medical practitioners for decades.

The AMA, claiming to represent "organized medicine," has instead said "Yes!" to more lawsuits, thus potentially opening a new venue for trial lawyer litigation.

During 2000-2001, the AMA considered HMO lawsuits more important than tort reform, despite the fact that about 90 percent of physicians support tort ("malpractice") reform and, conversely, 75 percent of them believe trial lawyers would have the most to gain from HMO lawsuits.

It sounds like a good idea to make things easier for patients who want to sue their HMOs and employers for delayed or mismanaged care. But who in fact will benefit from opening another Pandora's box of litigation? The trial lawyers, of course, not the patients, who most likely will die or whose health will worsen as they wait and wait stressfully and in an adversarial environment for the slow wheels of civil litigation to turn in their favor.

"You would think ... the AMA and organized medicine would remain sensitive to the problem of medical litigation and the pain-and-suffering lawyers and lawsuits have inflicted on medical practitioners for decades."

The AMA's leaders have lost sight of their mission and, unless pushed by the membership in the trenches, appear to have trouble recognizing the face of the enemy.

Since as far back as 1998, the AMA has alienated the who's who of the Republican Party, from Georgia Rep. Charlie Norwood and Oklahoma Sen. Don Nickles to affable House Speaker Dennis Hastert, who complained "these guys [AMA leaders], as far as I am concerned, are toadies of the Democrats."

Deja vu

The headline of the "professional issues" section of the July 8-15, 2002, issue of *American Medical News* declared: "AMA readies for battle on tort reform." The subtitle went on to state, "the ambitious plan passed at the Annual Meeting could cost more than $15 million to carry out, with $12 million set for a national ad campaign to educate the public."

It would appear the AMA leadership has finally heard the message of the rank and file private practitioners and now has seriously considered tackling the festering problem of the medical liability crisis. Indeed, the leadership of organized medicine has assigned it the "highest legislative priority."

The voices have been heard, and the medical politicians have talked the talk. Will they follow through and walk the walk? Only time will tell. Frankly, looking at their track record, I have my doubts.

Miguel A. Faria Jr. M.D. is editor-in-chief of the Medical Sentinel, *the peer-reviewed publication of the Association of American Physicians and Surgeons (AAPS), and author of* Vandals at the Gates of Medicine *and* Medical Warrior. *He can be reached by email at* hfaria@mindspring.com. *This article summarizes a larger work, published with references, in the Fall 2002 issue of* Medical Sentinel.

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MALPRACTICE REFORM

CONTINUED FROM PAGE 1

ceilings, whether higher or lower than caps set by the HEALTH Act itself.

Senator John Ensign (R-Nevada) introduced a bill similar to the House version (S. 2793), but the Senate has failed to act on the measure. Despite House passage of the HEALTH Act and strong support from the Bush administration, federal malpractice reform will not become a reality without Senate action.

California

The House measure mirrors in many important aspects the California Medical Injury Compensation Act (MICRA), which has been in effect for more than 25 years. MICRA caps non-economic damages at $250,000. It also:

- specifies a three-year statute of limitations on medical malpractice claims;
- permits defendants to make periodic payments rather than a lump sum in cases where awards are made for future economic damages of more than $50,000; and
- limits contingency fees to 40 percent of the first $50,000 recovered; 33 percent of the next $50,000; 25 percent on the next $500,000; and 15 percent of any amount exceeding $600,000.

MICRA appears to have immunized California from a legal crisis driving physicians from many other states. Due to steep increases in malpractice insurance premiums, which now often exceed $100,000 per year, physicians in states without malpractice reforms are increasingly cutting back on their areas of practice, moving to other states, or retiring from the medical profession at the peak of their careers.

Despite—or perhaps because of—the U.S. Senate's inaction on malpractice reform, several states have followed California's lead, taking it upon themselves to protect physicians from excessive jury verdicts and related malpractice insurance costs.

Florida

A malpractice insurance task force is currently analyzing the Sunshine State's spiraling malpractice insurance premiums. It will present a proposed solution to Governor Jeb Bush (R) in January.

Malpractice insurers report they paid out more than $250,000 in malpractice cases more than 300 times in 2001. Without curbs on these high awards—many of them far in excess of the $250,000 threshold—insurers say they cannot slow down escalating premiums.

"The only thing that will bring premiums down is to cap non-economic damages at some level," said Robert White of First Professionals Insurance Company.

Bush agrees action is needed to curtail the rising premiums that are driving many practicing physicians to other states. He reported many of the doctors who do stay are refusing to perform certain procedures deemed by insurers to be especially risky.

"This will be, if not our highest priority, it will be in the top one or two" during the coming year, said Bush in remarks to the Select Task Force on Healthcare Professional Liability Insurance. "I'm for caps on non-economic damages," he said after the Task Force meeting. "If you look at the states that have meaningful caps and you compare it to the states like Florida that don't, and you compare insurance premiums, you'll see."

Proponents of malpractice reform point out that Florida doctors pay significantly higher malpractice premiums than doctors in California, even though Florida's cost-of-living is significantly lower than California's.

Both houses of the Florida legislature are controlled by Republicans, and the leaders have expressed support for malpractice reform. The recommendations of the insurance task force are expected to significantly shape the language of any bills originating in the legislature. The legislature, currently in recess, reconvenes in March.

Mississippi

Democratic Governor Ronnie Musgrove signed a malpractice bill into law on October 8, culminating a special session of the Mississippi legislature and ending months of deadlock on the issue of tort reform.

The compromise legislation caps pain-and-suffering damages at $500,000, with incremental increases to $1 million in 2017. The legislation also requires plaintiffs to file malpractice suits in the county where the alleged injury occurred, and limits physician responsibility in cases where multiple persons are to blame for an alleged injury.

"Today, Mississippi's health care crisis has been addressed," said Musgrove after signing the bill. "The end result of this long special session was a piece of legislation offering a foundation for better health care in Mississippi."

The governor added the new bill sends a message to the rest of the country that "Mississippi is a good place to practice medicine."

Mississippi Trial Lawyers Association President David Barrie vowed to challenge the law in court. "I'm terribly unhappy," said Barrie. "It does nothing to fix the doctor's problem of getting affordable insurance."

"It's a good piece of legislation," countered Dr. John Cook, president of the Mississippi State Medical Association. "This will open the door for insurance companies to come back to Mississippi." Cook predicted malpractice insurance rates will stabilize within two years as a result of the new law.

The legislation passed the Mississippi House by a vote of 87-32. The Senate passed the measure 41-6.

New Jersey

The Medical Society of New Jersey predicts 3,000 physicians in the state will lose medical malpractice coverage this year as insurers pull out of the market. Medical liability insurers are also lowering insurable limits, and some are offering only claims-made policies.

Currently there are as many as 20 liability bills pending in the state legislature.

Nevada

In Senator John Ensign's (R) home state of Nevada, Republican Governor Kenny Guinn called a special legislative session to address skyrocketing malpractice insurance rates and the resulting exodus of physicians from the state. In response, the legislature passed a tort reform package that took effect last October. The legislation caps pain-and-suffering damages at $350,000, but allows exceptions for gross malpractice and cases where a judge finds "exceptional circumstances."

"[T]he federal government's inability to act on a malpractice reform measure failed to deter several states from taking the matter into their own hands ..."

Physicians have asserted the compromise legislation has not gone far enough, and that malpractice insurance premiums have failed to moderate. Medical liability insurance companies have not lowered their rates, at least in part because trial lawyer groups and other opponents of the new law have launched legal challenges to the legislation, which could take years to conclude. Insurance companies are wary of lowering rates only to later discover the legislation has been invalidated.

"The bill we all passed provided long-range remedies that everybody knew were long-range," said attorney Gerald Gillock, an opponent of malpractice reform.

To solve the short-term problem while the October legislation is resolved in the courts, Nevada citizens have drafted a Keep Our Doctors in Nevada petition and acquired enough statewide signatures to force the legislature to consider further malpractice

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reforms. The petition calls for limits on attorney fees for malpractice trial lawyers and would abolish the exceptions to the pain-and-suffering caps under the October 1 legislation. Additionally, the petition would ensure doctors pay for only the percentage of a malpractice award that is related to their culpability.

With the petition acquiring more than 77,000 signatures, the legislature now must either pass the proposal or reject it within 40 days after the legislature reconvenes in February. If the legislature rejects the proposal, it will appear on a statewide ballot in 2004. The legislature could recommend alternative legislation, which would also go before the voters in 2004.

With insurance premiums still rising despite the October legislation, doctors continue to shut down their practices or leave Nevada entirely. According to the Clark County OB/GYN Society, nearly 30 obstetricians have left Las Vegas, and others are refusing to accept new patients. "We have only about 80 doctors delivering babies now in Clark County," said Dr. John Nowins, president of the society.

With 42 of the 80 remaining obstetricians facing insurance renewal in the first half of 2003, Nowins fears one-third or more of those doctors will leave the area if the legislature fails in February to enact the proposed legislation.

"Democratic Governor Ronnie Musgrove signed a malpractice bill into law on October 8, culminating a special session of the Mississippi legislature and ending months of deadlock on the issue of tort reform."

"This package would help keep people in town," said Nowins. "Some feel they can stay and somehow afford to pay over $100,000 a year in premiums, but others are choosing not to."

"An unprecedented number of doctors are leaving Las Vegas," added Dr. Tom Purdon, former president of the American College of Obstetricians and Gynecologists. "Southern Nevada has become the worst place in the country for women trying to find prenatal care."

"With the sudden shift in the number of OB patients, it's making gynecological appointments harder and harder to come by," agreed Las Vegas obstetrician Brent Oliver. "Even in the last six months it's gotten worse. There are so many people calling for appointments, there's no way you can take everybody."

"We're optimistic that with the support of the people of Nevada, the Senators and Assembly people will actually listen and take action to pass the initiative," said Dr. Rudy Manthei. "We hope this passes in February, but if not, at least it goes to the voters and we have something to fall back on."

"I'm going to do everything I can to make sure this measure gets defeated in the legislature," responded attorney Gillock. "It's not fair to those that are injured."

Ohio

The Ohio House of Representatives passed its own version of malpractice reform on December 3. By a 64-33 vote, the House approved a substitute for Ohio Senate Bill 281, which offered various protections for doctors accused of medical malpractice. The Senate will now consider the House version of the bill and, if it approves, will send the bill to Governor Bob Taft (R).

The proposed legislation attempts to thwart a crisis in rising insurance premiums driving insurance companies and local physicians out of the state. In addition to capping pain-and-suffering awards, a key provision of both the House and Senate versions of the proposed legislation is the creation of a cash pool to cover 30 percent of $500,000 awards and 50 percent of $1 million awards. Responsibility for funding the pool remains to be determined. In neighboring Indiana, a similar pool is funded solely by physician contributions. In Ohio, contributions may be more broadly based.

The House made several key changes to the Senate bill. These include:

- increasing a part of the cap on catastrophic damages from $750,000 to $1 million;
- cutting another part of the catastrophic damages cap from $35,000 per year of life expectancy to $15,000 per year of life expectancy;
- eliminating a cap on attorney fees;
- instructing the Ohio Department of Insurance to recommend how to implement the proposed cash pool; and
- extending the period for plaintiffs to file malpractice claims.

House Speaker Larry Householder (R-Glenford) predicted the bill would halt steep increases in malpractice insurance premiums and provide physicians with incentives to remain in the state. Just as importantly, the bill would still allow people to take their cases to juries and would not limit economic compensation, such as lost wages.

"I think it's an effective way to address the problem that we have," said Householder.

Representative Timothy Grendell (R-Chesterfield), who introduced the House bill, said he doesn't care whether the state adopts the Senate bill or his House bill. "I'm not into pride of ownership," said Grendell. "We're just running out of time, and this is the quickest way to do it."

Pennsylvania

A reform bill signed in March 2002 by Governor Mark Schweiker (R) allows periodic payouts for judgments, requires claims to be filed within seven years of injury, and caps punitive damages at two times actual damages. The law also requires lawsuits to be filed in the county where the alleged malpractice occurred. Pennsylvania does not cap pain-and-suffering awards, and joint and several liability—which holds each defendant responsible for the entire amount of the plaintiffs' damages—remains in place.

The reform measure was the result of recommendations for short-term reform made by a Schweiker-appointed task force of doctors, trial lawyers, hospital administrators, and insurance executives. The group has until May 2003 to craft long-term policies.

The March reform bill did not keep Phico, one of the state's largest writers of medical liability coverage, from going into liquidation. Miix Group and Princeton Insurance have ceased writing new business in the state.

"This is a serious problem," observed Governor-elect Ed Rendell (D). "We are taking it seriously."

West Virginia

In December 2001, a bill guaranteeing all health care providers in the Mountain State access to liability insurance was signed by the governor. The measure is a variation on the California MICRA bill, providing for a $1 million cap on non-economic damages and not permitting defendants to make periodic payments on economic damage awards.

The bill does not appear to have improved the state's medical malpractice climate. Physicians are ceasing to practice there due to rising medical liability premiums, and trauma centers are closing at a rapid pace.

James M. Taylor is an attorney and managing editor of The Heartland Institute publication, Environment & Climate News. *Conrad F. Meier, managing editor of* Health Care News, *contributed to this report.*

Employer May Be Liable for Medical Advice

BY JAMES M. TAYLOR

The Employee Retirement Income Security Act (ERISA) does not prevent a plaintiff from suing her deceased husband's employer and the employer's medical services provider for advising the employee to stay in Saudi Arabia for dangerous surgery, according to the federal Court of Appeals for the Ninth Circuit.

The widow sued her husband's employer, Lucent Technologies, and its medical services provider, SOS, for alleged negligence regarding failed medical surgery that resulted in the husband's death.

The employee worked in Saudi Arabia at the time he learned he needed surgery. Upon learning that the type of surgery he required had never been performed in Saudi Arabia, the employee asked SOS whether he should be treated in another country. SOS and a Lucent doctor advised him to remain in Saudi Arabia. Evidence suggested the Lucent doctor based his advice at least in part on Lucent's inability to return the employee's passport in time for his required surgery. The employee complied with the advice, but then died as a result of the surgery.

"Upon learning that the type of surgery he required had never been performed in Saudi Arabia, the employee asked SOS whether he should be treated in another country."

A federal trial court in Oregon determined the widow could not sue Lucent or SOS because ERISA preempted the widow's claims. However, the court of appeals reversed most of the trial court's decision.

According to the appellate court, the claim against Lucent for choosing SOS as its medical services provider is preempted by ERISA. However, Lucent could be sued for negligently handling the employee's passport in a manner that prevented him from receiving proper medical care. Additionally, the widow could sue SOS and Lucent for negligently advising the employee to remain in Saudi Arabia for his surgery.

The court of appeals remanded the case for a jury trial in the Oregon trial court.

James M. Taylor is an attorney and managing editor of The Heartland Institute publication, Environment & Climate News.

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MSAs Are Not FSAs Are Not HRAs

BY VICTORIA CRAIG BUNCE

Faced with alarming increases in health care costs, employers are turning to consumer-driven health plans to help rein in expenditures.

Such consumer plans include Medical Savings Accounts (MSAs), Health Reimbursement Arrangements (HRAs), Flexible Spending Accounts (FSAs), and defined-contribution plans that give employees a fixed amount of money with which to purchase their own health policy. Many consumers and employers are confused about the differences among plans and which approach is best.

The *Washington Post* recently reported the American Postal Workers Union is giving its employees a "Medical Spending Account" option. Not to be confused with Medical *Savings* Accounts (MSAs), the postal workers were getting an HRA option. Indeed, current federal MSA legislation makes it illegal for the union to establish a tax-free MSA.

SIDE-BY-SIDE COMPARISON
Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs)

	MSA	FSA	HRA
Who "owns" it?	Individual/Employee.	Individual/Employee.	Employer.
Who funds it?	Employer or employee (but not both), or self-employed individual.	Typically funded by employee.	Employer only (self-employed precluded).
How is it funded?	Money is deposited directly into the account.	A set amount of pretax wages designated by the employee is deposited directly into an account.	Employer reimburses employee when presented with a valid receipt.
Is it a personal account?	Yes.	Yes.	It is an "Arrangement," not an "Account."
What type of corresponding health plan is allowed?	Only high deductible.	Any type of health plan arrangement.	Any type of health plan arrangement.
Does interest accrue?	Interest can be accrued tax free in qualified MSAs.	Interest not accrued.	Interest not accrued or addressed in IRS regulations.
Is it portable?	Rollover is allowed — individual owns MSA, takes it when leaving employment.	Unused funds must be spent by year's end (or by termination of employment before year's end), otherwise individual loses money.	HRAs cannot be rolled over to a new employer. An employer is under no obligation to continue the arrangement after employee departure, however an employer may chose to continue reimbursing a former employee's expenses from the HRA.
Can funds be used for non-medical expenses?	Funds used for non-medical expenses are taxed as income and incur a 15% penalty. After age 65 there is no penalty.	No, health portion of FSA only used for expenses defined under 213(d) of IRC.	No, only expenses defined under 213(d) of IRC.
What is the tax treatment?	Qualified MSAs are tax free as long as funds are spent on medical care defined under 213(d).	Contributions to FSA are tax free and so reduce annual taxable income.	Reimbursements to employee are tax free as long as they are used on qualified health care purchases.

Medical Savings Accounts

Medical Savings Accounts are health plans combining a high-deductible health insurance policy with a savings account. The high-deductible policy protects the insured from the cost of a catastrophic illness, prolonged hospitalization, or a particularly unhealthy year. The savings account is controlled by the insured and is intended to pay routine health care expenses.

Deposits to federally qualified MSAs (often referred to as Archer MSAs) are tax-free income for the employees whose accounts receive it. MSA funds not spent by year's end may be withdrawn or rolled over to the next year, accumulating with interest. Those who withdraw MSA funds for purposes other than health care expenses must pay the taxes they avoided plus a 15 percent penalty.

Congress authorized federally qualified MSAs under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). At the same time, it imposed a number of restrictions that reduce the workability and appeal of MSAs. For example, only the self-employed and employees working for small businesses can have a tax-free MSA. Employers or employees, but not both, can contribute money to the MSA.

Flexible Spending Accounts

Congress authorized FSAs under the Revenue Act of 1978. FSAs allow employees to contribute some of their own salary to an account to pay for health care expenses or their share of health insurance premiums. Like Archer MSAs, contributions to an FSA are exempt from both income and payroll taxes. However, under the tax code, only employers can establish FSAs for their employees, so the self-employed and millions of employees whose employers don't offer FSAs are prohibited from creating accounts.

The biggest downside of FSAs is the use-it-or-lose-it provision. While employees contribute the money, employers can keep any unspent balance at year's end. Because it is difficult for a family to predict its annual medical expenses, employees often overfund their accounts and by December find themselves spending on unnecessary or frivolous health care so they will not have to forfeit the remaining money to their employers.

Health Reimbursement Arrangements

HRAs—the A is for "arrangements," not "accounts"—are the newest form of consumer-driven health plan. In June 2002, the IRS authorized them and published guidance regarding their tax treatment.

HRAs allow an employee to use employer's money solely for medical expenses. The funds are owned by the employer, not by the employee, and they may not be withdrawn for non-medical expenditures.

If an employer permits withdrawals for non-medical expenses, its HRA plan will be disqualified for all employees, who will owe taxes on all amounts paid out of the HRA, including all prior medical reimbursements.

> "[M]any consumers and employers are confused about the differences among [consumer-driven health care] plans and which approach is best."

Unspent HRA balances may accumulate from year to year, and employers may or may not allow departing employees access to the balances after they have left the company. In practice, most employers do not make the funds available to former employees.

It's All about Incentives

The accompanying table offers a side-by-side comparison of the pros and cons of MSAs, FSAs, and HRAs. One of the main differences between them is the financial incentive to be a value-conscious health care consumer. HRA and FSA funds do not belong to the employee, and therefore they offer the employee little incentive to control spending. Indeed, the only way to gain value from HRA or FSA funds is to spend. Such programs might actually increase health care spending rather than reduce it.

Congress could, however, change the FSA's use-it-or-lose-it rule to a use-it-or-save-it provision. It could also give employees an ownership right to their HRA funds. Better yet, Congress could eliminate the restrictions on Archer MSAs so that all employers and employees would have access to a wide range of MSA plans.

Victoria Craig Bunce is director of research and policy at the Council for Affordable Health Insurance, CAHI. She can be reached by email at torybunce@cahi.org

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CONGRESS continued from page 1

government-run benefit within the current Medicare program.

The cost of the drug benefit will be a major sticking point. Proposals currently under discussion would cost at least $350 billion over 10 years, with some more comprehensive proposals carrying a price tag as high as $1 trillion over that period. It may be difficult to find revenue sources for such expensive proposals.

The 108th Congress is also expected to tackle broader reforms to the Medicare program. Many House Republicans and President George W. Bush have expressed interest in reforming Medicare Plus + Choice, changing provider payment formulas, and initiating competitive bidding for medical equipment. The prescription drug benefit debate will open the door for debate on how to address the long-term stability of the program.

The Uninsured

According to the Census Bureau, about 41.2 million people in the U.S. are without health insurance. This is a problem Congress cannot ignore.

Republicans, led by President Bush, would like to build on the example set by the trade bill to provide tax credits for the purchase of private insurance. Many Democrats, by contrast, are already preparing proposals that would expand current public programs, impose employer and individual mandates, or establish a single-payer system.

In his 2003 budget, Bush proposed a tax credit program for the uninsured that would provide a $1,000 tax credit for individuals, and $3,000 for families, who purchase private insurance. Bush is likely to include the plan in the 2004 budget.

Sen. Edward Kennedy (D-Massachusetts) is expected to offer a proposal that would force employers with five or more workers to provide health insurance coverage to workers and their dependents. A bill with an individual mandate is forthcoming from Sen. John Breaux (D-Louisiana).

Affordable Health Insurance

With health insurance premiums increasing about 12.7 percent in 2002, many employers are requiring employees to bear more of the premium cost ... or they're dropping coverage altogether. Congress needs to find ways to make health insurance more affordable, or many more Americans will join the ranks of the uninsured.

Health Policy Agenda for the 108th Congress

DO	DON'T
Adopt a Medicare Rx Benefit	Allow Drug Reimportation
Adopt Tax Credits for Uninsured	Weaken Drug Patent Protection
Expand MSAs	Adopt a Patients' Bill of Rights
Create Association Health Plans	Impose Employer Insurance Mandates
Reform Medical Malpractice	

One especially effective measure Congress could take would be to expand the availability of Medical Savings Accounts. Under current law, MSAs are available only as a demonstration project that must be periodically renewed, and enrollment is limited to 750,000 people who are either self-employed or employed by small businesses. Insurers have been hesitant to offer MSA products to a market kept small by these rules.

Congress could also allow flexible deductibles in the insurance component of the plan to make MSAs more affordable. Currently the plans can be offered with only a narrow range of deductibles. Moreover, current MSA rules allow only the employer to contribute to the account. Allowing employees to contribute to their own spending accounts would make MSAs more attractive to consumers seeking more control over health care spending decisions.

Association Health Plans

The creation of new purchasing pools for small businesses, called Association Health Plans, would make health insurance more affordable for small businesses while giving them some of the advantages enjoyed by large employers.

Small businesses have been hit hardest by rising health care premiums. Few can afford premium increases of 12 percent or more each year, especially in a slow economy. Small businesses are hurt further by costly coverage mandates, from which large self-insured companies are exempt.

Census Bureau figures show Americans who work for businesses with fewer than 25 employees were half as likely to have health insurance last year as those who work for companies with more than 1,000 employees.

Association Health Plans would help alleviate this problem by allowing small businesses to band together to purchase health insurance through associations, reducing the costs to any one business through economies of scale. The availability of such purchasing pools would make it easier for small businesses to provide health insurance.

Medical Malpractice Reform

The cost of medical malpractice insurance is so high in some states that doctors are moving their practices to other states or retiring from the profession completely. [See "Medical Liability Reform: A Physician's Perspective," page 8.] The problem is particularly acute for high-risk specialists such as OB/GYNs and neurosurgeons.

Soaring malpractice insurance rates are caused by high jury awards, which can be in the millions of dollars. Jury Verdict Research, which tracks jury awards, reports awards have increased 175 percent since 1994, to a median of $1 million in 2000.

Congress can address this problem by passing a tort reform bill. In September of last year, the House passed a measure that capped pain-and-suffering awards at $250,000 and punitive damages at $250,000 or twice economic damages, whichever is greater. The Senate killed the measure by failing to act on it. [See "States Take Lead on Medical Malpractice Reform," page 1.]

More Work to Be Done

If Congress has the time and political will, it might also tackle Medicaid reform this session. The program's antiquated funding formula and open-ended structure have made it the principal cause of budget deficits in states across the country. Congress could help address the problem by giving states the flexibility to use Medicaid funds for private coverage options and giving consumers more control over how that money is spent.

Finally, Congress could make Flexible Spending Accounts (FSAs) more consumer-friendly by eliminating the use-it-or-lose-it rule. FSAs allow employees to set aside a portion of their salary tax-free for out-of-pocket health costs. But the accounts are owned by employers, not employees, and current law allows employers to take back the balance in the account at the end of the year. By allowing the FSA to roll over tax-free from one year to the next, Congress would encourage consumers to save money for large medical expenses and end the perverse incentives that encourage inefficient spending at the end of the year.

Best Unaddressed

Some issues are best left untouched, lest Congress adopt "reforms" that take choices away from consumers or make health insurance more expensive.

Liberalizing restrictions on prescription drug reimportation from foreign countries and loosening legal protections for drug patents would discourage U.S. pharmaceutical companies from investing in new drug research and development, hurting consumers by making the industry less innovative.

After years of partisan wrangling, patients' rights legislation appears to be a dead issue. Many states and HMOs have taken action to implement some parts of the proposed legislation, and any federal legislation at this point would likely be counterproductive, imposing costly mandates and tempting over-litigation by trial lawyers.

All the Right Moves

Even without pharmaceutical industry regulation and patients' rights legislation, the 108th Congress has before it an aggressive agenda for free-market health care reform. By taking some or all of these actions, Congress can help put consumers back in charge of their health care decisions and make health insurance and prescription drugs more affordable and accessible.

President Bush, House Speaker Dennis Hastert (R-Illinois), and Senate Majority Leader Trent Lott (R-Mississippi) have said health care issues will be given a high priority in the 108th Congress. That may prove an excellent decision for them politically, if they can deliver. Voters will remember the promises made during the 2002 elections.

Joe Moser is a health policy analyst at the Galen Institute, a not-for-profit public policy research organization based in Alexandria, Virginia. The views expressed here are the opinions of the author and do not necessarily reflect the views of the Galen Institute.

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Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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BY MICHAEL A. GLUECK, M.D.
AND ROBERT J. CIHAK, M.D.

Congressional scandals come in two varieties. One involves criminality, malfeasance, dark and secret things. The other involves what they do legally—right out in the open—not caring much who notices or complains.

It's time to notice the scandal of congressional health insurance—the kind they provide for themselves and almost 9 million active and retired federal employees. And it's time to complain. Not because theirs is too good: We certainly don't begrudge them that. The scandal is that they're unwilling to let senior Americans enjoy the same level of choice and care.

A recent national poll by McLaughlin & Associates for the United Seniors Association, released on September 25, 2002, reveals a large discrepancy between the Medicare medical coverage Congress legislates for seniors and what members of Congress provide for themselves and other federal government employees.

If medical care were food, Congress would be offering seniors a no-choice fast-food snack. Seniors say they want a variety of healthy meals. Meanwhile, federal employees mandate a gourmet selection for themselves.

The McLaughlin survey polled 800 likely voters over the age of 50 on September 4-8, 2002. The accuracy is within +/- 3.5 percent at a 95 percent confidence interval. The results are clear.

Senior voters want:

- voluntary—not mandatory—choice of health and prescription drug programs;
- voluntary and affordable access to safe, quality medicines;
- their own doctors—not the government's—deciding what's important for seniors' health;
- minimal bureaucracy and government intervention.

What seniors don't want is also clear. They don't want:

- to be forced to leave their current prescription plan and enter a government program;
- one-size-fits-all, government-run health care;
- government bureaucrats controlling what medicines they can get;
- government interfering in their relationship with their own doctors.

Put differently, seniors want what retired federal government employees already have: choices.

Under the Federal Employees Health Benefits Program (FEHBP), insurance companies design health plans to appeal to federal government employees and retirees in different circumstances and in different parts of the country.

For 2003 these private health plans are competing to enroll federal employees in one of 188—yes, 188—different health insurance plans. Each person has the opportunity to choose the option best suited to that person's medical wants and desires.

As Robert Moffit Ph.D., director of domestic policy at The Heritage Foundation and former assistant director of the United States Office of Personnel Management, recently wrote: "Unlike many retirees in the private employer-based health insurance system, federal retirees enrolled in the FEHBP have routine access to the full range of health benefits available to active federal employees and are not burdened by extraordinary rate increases or cutbacks in benefits or coverage."

"It's time to notice the scandal of congressional health insurance—the kind they provide for themselves and almost 9 million active and retired federal employees. And it's time to complain."

This year, the American Postal Workers Union, a large postal employees' union, will offer federal employees (not just postal service employees) a health care spending account worth $1,000 per person or $2,000 per family. Employees will be able to draw on this account to pay directly for routine medical expenses, and any money left over in the account will accumulate and be available in following years, similar to a Medical Savings Account plan.

Moffit writes, "FEHBP enrollees will be able to have access to Flexible Spending Accounts, a tax-free health-care account now available to millions of workers in many private corporations for out-of-pocket payments for medical services." This option "would allow federal workers to deposit up to $3,000 a year in an account tax free to pay for out-of-pocket expenses and up to $5,000 a year tax free for child care and the care of aged parents."

The federal government's "Do as we say, not as we do" phenomenon is no new thing. It didn't surprise us when the rhetoric of the Clinton health plan of the early '90s—supposedly "good for all Americans"—wasn't good enough for Congress. Members of Congress sought to exempt themselves and other federal employees from the plan. They and the government employees' unions pushed to continue the multiple choices available in their own FEHBP instead of the Clinton proposal for a government-run monopoly.

However, when it comes to choices in medical care, "Do as we say" is not acceptable. Congress should be "doing unto us what they do for themselves." All voters want is the freedom to choose the quality of care they want, at least as good as the choices members of Congress give themselves and almost 9 million other federal employees.

Michael Arnold Glueck M.D. is an award-winning writer who comments on medical-legal issues. Robert J. Cihak M.D. is a former president of the Association of American Physicians and Surgeons.

Faria Appointed to CDC Committee

Dr. Miguel A. Faria Jr., a retired neurosurgeon, former Clinical Professor of Surgery (Neurosurgery) at Mercer University School of Medicine, and contributing editor to *Health Care News*, was appointed in September to the Injury Research Grant Review Committee of the Centers for Disease Control and Prevention (CDC).

Faria began serving his term immediately, despite reported opposition by several CDC officials. Secretary of Health and Human Services (HHS) Tommy G. Thompson, who appointed Faria, defended his nomination and pointed to the Committee's charter, which calls on it to "ensure that the diverse perspectives of leaders in injury prevention and control are considered in planning, establishment, implementation, and evaluation of the overall injury research program."

Gun Control Controversy

Faria was one of three physicians who in 1996 testified before the House Appropriations Subcommittee for Labor, Health, and Human Services to eliminate funding for the CDC's National Center for Injury Prevention and Control (NCIPC) because of the agency's alleged use of biased science to promote a gun control agenda. Several weeks after that hearing, the NCIPC lost $2.6 million in funding and was prohibited by Congress via the Dickey Amendment to use taxpayer money to conduct "gun control research."

In July 1995, Faria was forced to resign as editor of the *Journal of the Medical Association of Georgia* because of his insistence on publishing articles on both sides of the gun control debate. Shortly thereafter, Faria accepted the position of editor-in-chief of the *Medical Sentinel*, the official, peer-reviewed journal of the Association of American Physicians and Surgeons (AAPS).

Faria contends medical journals should provide a balanced and objective approach to the problem of gun violence. He has testified that many medical journals instead publish politicized, biased research with predordained conclusions bolstering gun control. Much of that research was carried out by grants from the CDC. He insists that medical researchers have a moral duty and professional obligation to present both sides of a controversial issue, as necessary for the free exchange of ideas in a free society.

Among his duties as a member of the CDC's Injury Research Grant Review Committee, Faria "will provide advice and guidance to the HHS Secretary and Director, CDC, concerning the scientific and technical merit of grant and cooperative agreement applications received from academic institutions and other public and private profit and nonprofit organizations, including State and local government agencies, to conduct specific injury research."

For more information…

WWW about Dr. Miguel A. Faria Jr., visit the Web site of Hacienda Publishing at **www.haciendapub.com.**

For more information on the Association of American Physicians and Surgeons, for whose journal, *Medical Sentinel*, Faria serves as editor-in-chief, visit the AAPS Web site at **www.aaps.org.**

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State Legislative UPDATE

COMPILED AND EDITED BY CONRAD F. MEIER

A MONTHLY REVIEW OF STATE LEGISLATIVE ACTIVITY

ARKANSAS

Governor Mike Huckabee (R) recently proposed increasing the state sales tax by five-eighths of 1 percent to pay for Medicaid. State spending on the Medicaid program is projected to increase by $247 million in the next two years; the tax increase would provide roughly $79 million in general revenue needed for the program in 2003 and $107 million in 2004, according to state Medicaid Director Ray Hanley.

Hanley told *The Democrat-Gazette* the state needs to increase Medicaid funding to maintain the current level of Medicaid services. He said when matched with federal money, the $247 million increase would provide about $988 million for the program over the next two years.

FLORIDA

Governor Jeb Bush (R) and top state House and Senate lawmakers agree medical malpractice reform should be "one of the top issues" for the coming legislative session, according to AP Wire Services. The governor said, "We have a looming crisis that will impede or impact the quality of care and so we have to act. Some degree of litigation reform is necessary to attract insurance into the state."

State Senator Anna Cowin (R) said "a number of issues" are being addressed by a task force established by Bush, adding, "caps on pain-and-suffering damages would likely be a part of any bill" introduced in the Senate. House Speaker Johnnie Byrd (R) told the *St. Petersburg Times*, "caps would probably be one of the many solutions that would come up."

MAINE

Officials at the Veterans Affairs Medical Center in Togus, and its five clinics statewide, expect a 53 percent increase in the number of people seeking medical services at those facilities over the next 10 years, due in part to an aging veteran population and gaps in health insurance coverage.

The number of patients seeking treatment is expected to increase from about 40,000 currently to more than 60,000 by 2012. Jim Simpson, a spokesperson for the Togus VA center, attributed the anticipated increase to coverage gaps in private health insurance and Medicare. Simpson also said the number of Vietnam-era veterans entering the VA medical system is rising.

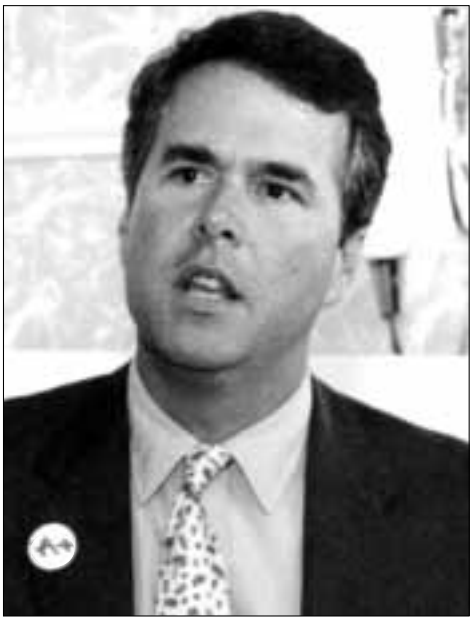
While patient volume is increasing, the Togus VA center is experiencing a shortage of providers. Currently, about 5,800 veterans are on the waiting list to see a physician, and some patients must wait a year to receive an appointment, Simpson said.

According to a brief AP report published by the *Portland Press Herald*, state officials are considering plans to contract with community clinics and hospitals to treat veterans. Last June the Department of Veterans Affairs announced plans to overhaul its health care system and analyze 1,200 VA health care facilities in an attempt to shift funds from aging, inefficient facilities in areas where the number of veterans is declining so the agency can offer additional services in communities with a growing number of veterans. (See "Elderly Veterans Ignored in Rx Policy Debate," *Health Care News*, August 2002.)

"We have a looming crisis that will impede or impact the quality of care and so we have to act. Some degree of litigation reform is necessary to attract insurance into the state."

GOV. JEB BUSH

(R-FLORIDA)



MARYLAND

The cost of health insurance benefits required by Maryland is nearing a state-mandated cap set to ensure affordability, according to a report by the Maryland Health Care Commission. Once the cap is reached price controls kick in.

Under a 1999 law, the annual cost of a policy covering state-mandated benefits is limited to 2.20 percent of the state's average annual wage. Maryland requires health insurance plans sold in the state to cover 25 mandates, including diabetes medications, mental health treatment, and hospital services for a two-day maternity stay.

Large, self-insured companies are exempt from the mandates. The report found the cost of a policy sold in Maryland covering only the 25 mandates is $841 per year, or 2.19 percent of the average annual wage. Given that health costs are increasing, the report said the ceiling is likely to be broken this year, even if the state legislature does not mandate any new benefits.

MICHIGAN

The *Detroit News* editorialized in favor of free-market health insurance, saying Michigan Governor-elect Jennifer Granholm (D) must "fundamentally restructure [Medicaid] and move it toward a more consumer-driven system" to avoid a crisis in the program.

The editorial states the Medicaid program has become the "biggest budget guzzler" because of the "lure" of federal matching funds. The fund match provides the state with 65 cents for every dollar it spends. This in turn acts as an incentive for the state to increase spending on Medicaid.

The editorial further said "possibly the worst" way to remedy Medicaid's increasing costs would be to raise taxes. Instead, Granholm should "redefine the eligibility criteria for Medicaid so it is once again, as originally intended, a safety net for the truly needy."

"Medicaid," the *Detroit News* concluded, "should resemble commercial insurance" and "buy umbrella private coverage for medical emergencies and acute health care problems—not to pay for a full slew of benefits."

Granholm, however, has said she would oppose a potential for-profit conversion of Blue Cross Blue Shield of Michigan because she believes such a move would "dramatically increase the number of uninsured."

She would also propose measures to expand access to Medicaid; MiChild, the state's CHIP program; and MiFamily, a state program for low-income adults who do not qualify for Medicaid and cannot afford private insurance. She would also use a greater percentage of the state's share of the national tobacco settlement for health services.

RHODE ISLAND

A taxpayer-funded study by the Coalition for Consumer Justice, a single-payer advocacy group, says a single-payer health care system could cover every resident of the Ocean State and cut current administrative costs for health care in half. Under a single-payer system, one government agency would collect the necessary fees, premiums, and taxes to fund the system.

According to the study, Rhode Island could set up such a system by redistributing the $7.2 billion it currently spends each year on health care. The state spends more than $7,000 per person and ranks fourth in the nation in total health care spending.

Alan Sager, the study's lead author and a Boston University professor, said he estimates the state would need to spend an additional $1 billion to cover people who do not have health insurance. The study also says more savings could result if the state negotiated discounts on medications with drug companies and if doctors managed care more responsibly. "These are not numbers we made up," Sager said. "This is the experience of countries where simplified financing exists and where doctors aren't on the phone negotiating with managed care."

Christine Ferguson, a representative of Governor-elect Donald Carcieri (R), said the "proposed solution is unlikely to win a following" because people do not "inherently trust the government to do that."

The study failed to examine the inflationary impact of state mandates like mental health parity and procedural mandates like guaranteed issue and community rating.

The State Legislative Update is compiled from a wide range of news sources, including the National Association of Health Underwriters (NAHU) http://nahu.org; *Bizjournals* http://bizjournals.com; *Stateline* http://stateline.org; *Kaiser Daily Health Policy Report* www.kaisernetwork.org; *and Lexis/Nexis research.*

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The Galen REPORT

A monthly review of health policy matters

It's already clear congressional and White House leaders really meant it when they promised health care issues will be a top priority in the 108th Congress.

Our schedules have been booked with wall-to-wall meetings and travel as members and staff—including many for whom health care has not previously been a priority—are scrambling to get ideas and initiatives ready for 2003.

The PDS Plan

The biggest demand is for information about the Prescription Drug Security plan Joe Antos of the American Enterprise Institute and I are developing.

We offer a structure for a privately delivered benefit that gives seniors a choice of plans with competitively negotiated price discounts. It builds an infrastructure for overall modernization of the program around the Federal Employee Health Benefits Program (FEHBP) model; provides the greatest subsidies to lower- and moderate-income seniors; and offers a chance for everyone to participate in catastrophic coverage—all goals of the House-passed drug bill. But we structure the subsidies in a new way that's gaining a lot of attention.

I was very privileged to be included in Secretary Tommy Thompson's meeting at the Institute of Medicine, expertly organized by John Hoff and his team at the Department of Health and Human Services.

Thompson wanted to explore ideas for programs to begin right away, including demonstration projects for medical liability, individual ownership of health insurance, better use of information technologies, prevention, and quality.

John brought together a diverse group of health experts, from business to labor to academics, who filled the day with ideas and insights. It won't surprise you that I focused on the importance of empowering consumers to be more engaged in decisions about their health care and health spending through tax credits or "health certificates."

The certificates (read: vouchers) would be redeemable at health insurance companies for major discounts on policies. They would be run through the spending side of the budget rather than through the tax system for those who don't owe taxes.

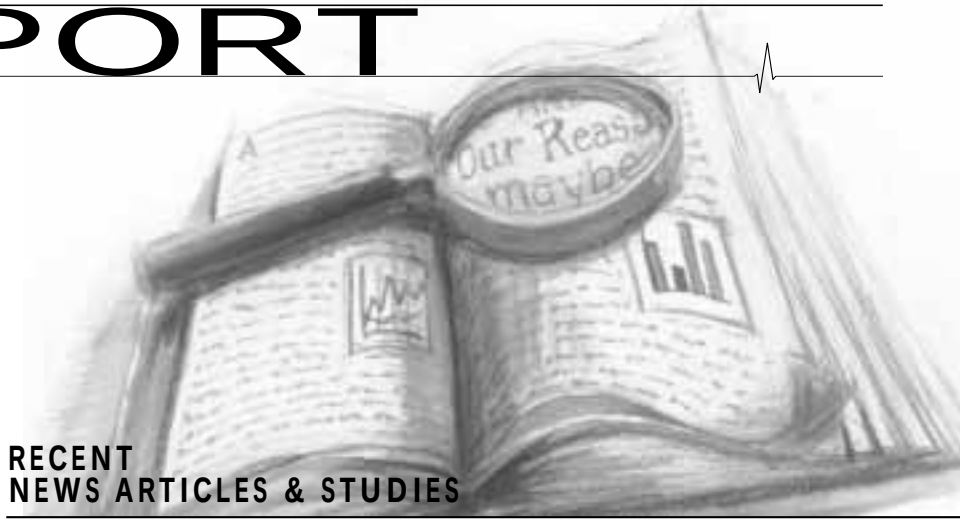
I was also in Palm Springs, California speaking to the California Medical Association at the invitation of their energetic and able Executive Vice President and CEO Dr. Jack Lewin. My topic was consumer-driven health care, and these docs say "Bring it on!" They are ready for change.

Jack also had the guts to invite three insurance executives to talk to the group, including physician Jack Rowe, who heads Aetna. The docs threw barbs at the execs, angry over the control their companies have over their lives and practices, with one coming to the microphone to proudly announce he had been able to fire each of the three companies from his practice.

Rowe did the best job of building a bridge between doctors and insurers since he is both. In fact, putting consumers in the driver's seat will help, forcing the two sides to be partners rather than adversaries.

Grace-Marie Turner

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of *Health Care News*.



RECENT NEWS ARTICLES & STUDIES

The Fantasy of Reference Pricing

John R. Graham
The Fraser Institute, 11/29/02

In 1995 Canada's British Columbia province developed a complicated system to contain government spending on drugs by subsidizing the price of less-expensive drugs and forcing patients to pay more for newer, more expensive medicines. But the plan has backfired: BC's "Pharmacare" costs have increased 38 percent more than costs in other provincial governments that do not discriminate between more-expensive and less-expensive drugs.

Also, the program has had negative consequences for patients' health. The Fraser Institute's John Graham suggests eliminating the failed program, which biases patients' choice against innovative and new medicines, and replacing it with a tiered network of co-payments that motivates doctors and patients to consider "value for money" and restores patient choice.

Full text: www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=448

A Gathering Storm in California Health Care

Naomi Lopez Bauman
The Latino Coalition Foundation, 12/5/02

The Golden State has some of the best medical care available, but "unfortunately, health care access, quality, choice, and affordability are becoming increasingly scarce in California," says Naomi Lopez Bauman. She says managed care has stripped consumers of control and reduced access to the newest medical treatments.

Bauman cites numerous studies to examine why costs are rising, how this impacts the availability of health coverage, and what can be done to give more choice and control over health decisions to the nation's largest minority community: Hispanics.

Full text (pdf): www.thelatinocoalition.com/issues/pdf/CaliforniaHealthCareStudy.pdf

Governors-elect Focus on Drug Costs, Medicaid Funds

Joel B. Finkelstein
American Medical News, 12/09/02

Health care reforms that lower prescription drug costs and expand Medicaid programs will be among the major goals for next year's governors-elect, says *AMNews*' Joel Finkelstein.

A state-by-state post-election review of health care proposals conducted by the National Academy for State Health Policy says three key areas will receive the greatest attention and action next year:

- pharmacy initiatives (44 percent of governors-elect have proposed one or more initiatives designed to make prescription drugs more affordable);
- Medicaid and SCHIP; and
- market-based initiatives, including tax credits, medical savings accounts, and defined-contribution programs.

Finkelstein says rising premiums for medical liability insurance will also become a key issue if the federal government does not pass tort reform legislation early next year.

Full text: www.ama-assn.org/sci-pubs/amnews/pick_02/gvsd1209.htm
National Academy for State Health Policy analysis: www.nashp.org/Files/Gov-Elect_Health_Policy_Analysis.pdf

Taking Health Care In-house

David Shook
BusinessWeek Online, 11/18/02

Ever-rising health insurance premiums are leading several large companies to develop radical new ideas for cutting medical costs while continuing to provide quality medical care to employees and their families, says BusinessWeek Online. Wisconsin-based printing company Quad/Graphics has hired its own doctors and nurses and taken its health care almost entirely in-house.

Quad/Graphics doctors see only about 12 to 16 patients a day, roughly half as many as an HMO doctor usually sees in a day. Its employees are "thrilled" and Quad/Graphics has seen many other benefits, including an annual savings of $6.5 million.

Full text: www.businessweek.com/bwdaily/dnflash/nov2002/nf20021118_0219.htm

The Impact of Social Security and Medicare on the Federal Budget

Congressional Budget Office, 11/14/02

The CBO reports in a "Long-Range Fiscal Policy Brief" that Social Security and Medicare will run a cumulative deficit of $6.6 trillion when properly accounted through 2026, not the surplus of $6.5 trillion the programs' trustees estimate.

CBO says internal transfers between Treasury accounts cause a distortion "that obscures the growing strains that the programs are placing on the government's finances."

Full text (pdf): ftp.cbo.gov/39xx/doc3982/11-14-LongRangeBrief6.pdf

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

Al Gore and the Liberal Dream

"If Gore or the NAS consider it important to warn the American people about the crisis in health care today, they also bear the responsibility to explain why that crisis exists. Public-sector failure, not market failure, lies at the root of today's problems. Promising more government intervention to solve a problem caused by government is, well, pretty dumb."

Former Vice President Al Gore recently began pounding the drum for health care reform. He told the nation what most of us already know: The U.S. health care system is in a state of crisis.

But in what has to be a classic example of intellectual exhaustion, Gore says he "reluctantly" arrived at the point where the reform he favors is the old, threadbare, and unworkable liberal dream: a single-payer health care system.

A few days after Gore's announcement, a suspiciously timed report by the National Academy of Sciences said pretty much the same thing, except it proposed a more modest agenda, urging the Bush administration to "test" possible solutions, including single-payer insurance coverage, in a handful of states.

A day after the NAS report was issued, Gore reinvented himself one more time and said he thought "the single-payer system should be run by the private sector."

Either antitrust after the Microsoft case really is dead, or Gore has now completely forgotten the difference between the private and public sectors.

Unless the former Vice President changes his mind once again, he apparently believes the money that pays for health care—including insurance premiums and tax dollars—should be collected by a single government agency in an approach similar to that taken by the dysfunctional health care systems of England, Canada, and our own Medicare.

A Universal Gripe

The people in Canada and the U.K. are no happier with their health care systems than we are with ours. Doctors and nurses trapped in government-run health care systems are leaving chosen careers, patients lack access to cutting-edge technology and facilities, and government health departments report record numbers of people dying while in queues.

Government-run systems in the United States, such as the Veterans Administration's health care program, Medicare, and Medicaid, have many of the same problems. Government control of care hasn't solved the underlying problem of unlimited demand and limited supply. It masks, shifts, and delays the tradeoffs that must eventually be made.

Gore's approach is purely political and dangerously dishonest, while the NAS report is based on selective evidence and the old bureaucratic dodge of calling for experiments and more research.

It's the Regulations

Instead of banging the drum loudly as a distraction, Gore and the NAS should have launched an honest and open discussion of how existing state and federal regulations, price controls, entitlement programs, and benefit mandates are responsible for the crisis in our health care system.

Over the past 40 years, 1,500 unfunded insurance mandates zipped through state legislatures and Congress because politicians saw them as an easy way to garner constituents' votes without having to raise state taxes or spend more on public health issues. Now, we're paying the price.

Government mandates require health insurance benefits to include everything from pastoral counseling to sperm-bank deposits. When combined with procedural mandates like "community rating" (which prevents insurers from basing premiums on risk factors like lifestyle choices) and "guaranteed issue" (which allows and encourages people to wait until they get sick before they buy health insurance), the bureaucratic chefs have created a toxic soup of regulations that is not-so-slowly and surely inflating the cost of private health insurance.

We Need a New Drummer

The average annual health insurance premium for an individual policyholder in California, which mandates neither community rating nor guaranteed issue, is $1,538. The average premium in highly regulated New York, which imposes both, is more than twice as much at $3,589. A Congressional Budget Office study revealed 200,000 people drop private health insurance every time premiums rise by 1 percent.

A recent PricewaterhouseCoopers study commissioned by the Association of Health Plans forecasted a health insurance premium increase of 13.7 percent for 2002. PwC attributed 15 percent of that increase to government mandates and regulations, 7 percent to litigation, and 5 percent to fraud and abuse.

If Gore or the NAS consider it important to warn the American people about the crisis in health care today, they also bear the responsibility to explain why that crisis exists. Public-sector failure, not market failure, lies at the root of today's problems. Promising more government intervention to solve a problem caused by government is, well, pretty dumb.

Millions of Americans can't afford the cost of insurance because of the mandates imposed by their representatives in government. What we need now is a drummer willing to criticize incumbent legislators who took the easy way out and helped cripple our market-based health care system—a drummer willing to lead the effort to eliminate existing regulations and mandates.

Al Gore, I've reluctantly concluded, is not that drummer.

Conrad F. Meier is managing editor of Health Care News.

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